

3989

CERTIFICATE OF DEATH

Reg. Dist. No.

03970

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whaleyville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whaleyville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION XXXX		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ELIZABETH First Middle Last		4. DATE OF DEATH March 11 Month Day Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 23, 1876
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William J. Davis		14. MOTHER'S MAIDEN NAME Kathryn Ennis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 215-26-5743	
17. INFORMANT Mrs Katie Baker		Address Bishop, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Mar 8 - , 19 58 , to Mar 11 - , 19 58 , that I last saw the deceased alive on Mar 11 - , 19 58 , and that death occurred at 10:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Chas R. Law		DATE SIGNED 3-12-58	
PHYSICIAN'S NAME (Type)		M.D. Berlin Md	
22a. BURIAL, CREMATION, or other disposition (Specify)	22b. DATE THEREOF 3/14/58	22c. NAME OF CEMETERY OR CREMATORY Dale	22d. LOCATION (City, town, or county) (State) Whaleyville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR 13 '58	
ADDRESS		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
 1. Name of deceased
 2. Date of death
 3. Place of death
 4. Cause of death
 5. Name of physician
 6. Name of funeral home
 7. Name of next of kin
 8. Name of informant
 9. Signature of informant
 10. Date of filing

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1. Name of deceased		2. Date of death		3. Place of death		4. Cause of death		5. Name of physician		6. Name of funeral home		7. Name of next of kin		8. Name of informant		9. Signature of informant		10. Date of filing	
11. Name of deceased		12. Date of death		13. Place of death		14. Cause of death		15. Name of physician		16. Name of funeral home		17. Name of next of kin		18. Name of informant		19. Signature of informant		20. Date of filing	
21. Name of deceased		22. Date of death		23. Place of death		24. Cause of death		25. Name of physician		26. Name of funeral home		27. Name of next of kin		28. Name of informant		29. Signature of informant		30. Date of filing	
31. Name of deceased		32. Date of death		33. Place of death		34. Cause of death		35. Name of physician		36. Name of funeral home		37. Name of next of kin		38. Name of informant		39. Signature of informant		40. Date of filing	
41. Name of deceased		42. Date of death		43. Place of death		44. Cause of death		45. Name of physician		46. Name of funeral home		47. Name of next of kin		48. Name of informant		49. Signature of informant		50. Date of filing	
51. Name of deceased		52. Date of death		53. Place of death		54. Cause of death		55. Name of physician		56. Name of funeral home		57. Name of next of kin		58. Name of informant		59. Signature of informant		60. Date of filing	
61. Name of deceased		62. Date of death		63. Place of death		64. Cause of death		65. Name of physician		66. Name of funeral home		67. Name of next of kin		68. Name of informant		69. Signature of informant		70. Date of filing	
71. Name of deceased		72. Date of death		73. Place of death		74. Cause of death		75. Name of physician		76. Name of funeral home		77. Name of next of kin		78. Name of informant		79. Signature of informant		80. Date of filing	
81. Name of deceased		82. Date of death		83. Place of death		84. Cause of death		85. Name of physician		86. Name of funeral home		87. Name of next of kin		88. Name of informant		89. Signature of informant		90. Date of filing	
91. Name of deceased		92. Date of death		93. Place of death		94. Cause of death		95. Name of physician		96. Name of funeral home		97. Name of next of kin		98. Name of informant		99. Signature of informant		100. Date of filing	

RECEIVED
 MAR 13 1958
 BUREAU V. 1

3990

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY WORCESTER MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND COUNTY WORCESTER			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BISHOP				c. LENGTH OF STAY IN 1b LIFE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BISHOP			
				f. STREET ADDRESS RFD			
3. NAME OF DECEASED (Type or print) GEORGE W. BENSON				4. DATE OF DEATH MARCH 6 1958			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 5, 1888	
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER				10b. KIND OF BUSINESS OR INDUSTRY OWN FARM			
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME WILLIAM BENSON				14. MOTHER'S MAIDEN NAME ELISABETH SAVAGE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 022-14-541			
17. INFORMANT McClennan Benson				Address Bishop, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Congestive heart failure DUE TO hypertension Cardio-vascular disease 3-4 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral vascular accident (c) arteriosclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerosis							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 1954 to March 6, 1958 , that I last saw the deceased alive on March 6, 1958 , and that death occurred at 3:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert A. Grubb, M.D.				ADDRESS (Street, city or town, state) BERLIN, Md.			
PHYSICIAN'S NAME (Type) ROBERT A. GRUBB, M.D.				DATE SIGNED 3-8-58			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 3/9/58		22c. NAME OF CEMETERY OR CREMATORY LOOF		22d. LOCATION (City, town, or county) (State) Bishopville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Peter Whaley, Bishopville, Md.				24a. RECEIVED BY REGISTRAR DATE			
				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF BIRTH [Faint text: ...]		PLACE OF DEATH [Faint text: ...]	
SEX [Faint text: ...]		AGE [Faint text: ...]	
OCCUPATION [Faint text: ...]		CAUSE OF DEATH [Faint text: ...]	
DATE OF BIRTH [Faint text: ...]		DATE OF DEATH [Faint text: ...]	
TIME OF DEATH [Faint text: ...]		PLACE OF INTERMENT [Faint text: ...]	
SIGNATURE OF DECEASED [Faint text: ...]		SIGNATURE OF WITNESS [Faint text: ...]	
SIGNATURE OF PHYSICIAN [Faint text: ...]		SIGNATURE OF CLERK [Faint text: ...]	

BUREAU V. S.

MAR 11 1938

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1. This form is to be filled out by the attending physician or the coroner. It is to be filed in the office of the Registrar of the State Department of Health. It is to be used for the purpose of obtaining a death certificate. It is to be filled out in duplicate. One copy is to be retained in the office of the Registrar and the other copy is to be forwarded to the office of the State Department of Health. It is to be filled out in duplicate. One copy is to be retained in the office of the Registrar and the other copy is to be forwarded to the office of the State Department of Health.

CERTIFICATE OF DEATH

Reg. Dist. No. 03972

3991

1. PLACE OF DEATH a. COUNTY <i>Worcester</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Worcester</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ocean City</i>		c. LENGTH OF STAY IN 1b <i>19 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Harry</i> Middle <i>Milton</i> Last <i>Brown</i>		4. DATE OF DEATH Month <i>March</i> Day <i>31</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 25, 1872</i>
9. AGE (In years last birthday) <i>85</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Photographer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Commercial</i>	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Henry Brown</i>		14. MOTHER'S MAIDEN NAME <i>Virginia W. Hittington</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>Spouse Lincoln</i>		16. SOCIAL SECURITY NO. <i>169-10-4517</i>	
17. INFORMANT <i>Ruth Brown</i>		Address <i>Ocean City Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CORONARY OCCLUSION</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>CORONARY SCLEROSIS</i> DUE TO (c) <i></i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i> <i>9 mos</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <i>March</i> Day <i>19</i> Year <i>1958</i> Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Nov</i> , 1957, to <i>31 Mar</i> , 1958, that I last saw the deceased alive on <i>31 Mar</i> , 1958, and that death occurred at <i>11:45 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. R. Thomas</i>		ADDRESS (Street, city or town, state) <i>Ocean City, Md.</i> DATE SIGNED <i>Apr 58</i>	
PHYSICIAN'S NAME (Type) <i>N. R. Thomas</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4/2/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Evergreen</i>	22d. LOCATION (City, town, or county) (State) <i>Berlin Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Peter Whaley</i>		24a. REC'D BY REGISTRAR <i>APR 7 '58</i>	
ADDRESS <i>Silgode, Md.</i>		24b. REGISTRAR'S SIGNATURE <i>Reed</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

File No.

PLACE OF DEATH		MARRIAGE	
1. CITY OR TOWN		1. CITY OR TOWN	
2. COUNTY		2. COUNTY	
3. STATE		3. STATE	
4. ZIP CODE		4. ZIP CODE	
5. DECEASED		6. DECEASED	
7. DECEASED		8. DECEASED	
9. DECEASED		10. DECEASED	
11. DECEASED		12. DECEASED	
13. DECEASED		14. DECEASED	
15. DECEASED		16. DECEASED	
17. DECEASED		18. DECEASED	
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21. DECEASED		22. DECEASED	
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91. DECEASED		92. DECEASED	
93. DECEASED		94. DECEASED	
95. DECEASED		96. DECEASED	
97. DECEASED		98. DECEASED	
99. DECEASED		100. DECEASED	

RECEIVED
APR 7 1958
BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill Rural #2</u>		c. LENGTH OF STAY IN 1b <u>30 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill Rural #2 Box 191</u> d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Jacob</u> Middle <u>Barbin</u> Last <u>Barbin</u>		4. DATE OF DEATH Month <u>March</u> Day <u>10</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 5 - 1881</u>
9. AGE (In years last birthday) <u>76 1/2</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Smart Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Snow Hill, MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Samuel Barbin</u>		14. MOTHER'S MAIDEN NAME <u>Jane Atkinson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name and dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Leamon Bratten</u> Address <u>Snow Hill, MD #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 10</u> , 19 <u>58</u> , to <u>March 10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>March 10</u> , 19 <u>58</u> , and that death occurred at <u>11:45 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. La Mar</u> M.D.		ADDRESS (Street, city or town, state) <u>104 BAY ST.</u> DATE SIGNED <u>3-12-58</u>	
PHYSICIAN'S NAME (Type) <u>Robert C. La Mar, M.D.</u>		<u>Snow Hill, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>March 14/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Deeds Chapel</u>	22d. LOCATION (City, town, or county) (State) <u>MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne Dennis</u> ADDRESS <u>Snow Hill, MD</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <u>Reberich</u>
		DATE <u>MAR 14 '58</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page No. 1

1. NAME OF DECEASED <i>John William Jones</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1893</i>	
5. PLACE OF BIRTH <i>St. Louis, Mo.</i>		6. OCCUPATION <i>Engineer</i>	
7. MARITAL STATUS <i>Married</i>		8. NAME OF SPOUSE <i>Anna Jones</i>	
9. CAUSE OF DEATH <i>Heart Disease</i>		10. PLACE OF DEATH <i>Home</i>	
11. TIME OF DEATH <i>10:30 AM</i>		12. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>	
13. SIGNATURE OF REGISTRAR <i>John D. Jones</i>		14. DATE OF DEATH <i>Mar 14 1938</i>	

BUREAU V. R.

MAR 14 1938

RECEIVED

3993

CERTIFICATE OF DEATH

Reg. Dist. No.

03974

1. PLACE OF DEATH a. COUNTY <i>Monester</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Monester</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Berlin (Rural)</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>1</i>	
3. NAME OF DECEASED (Type or print) <i>Baby Girl Corbin</i>		4. DATE OF DEATH Month <i>March</i> Day <i>11</i> Year <i>1958</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>N</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 11, 1958</i>
9. AGE (In years last birthday) yrs. <i>16</i>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Berlin Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Frank Smith</i>		14. MOTHER'S MAIDEN NAME <i>Maggie Corbin</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Lillie Johnson</i>		Address <i>Berlin, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Aspiration Pneumonia</i> 763.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>—</i> DUE TO (c) <i>—</i>			INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>3/11</i> , 1958, to <i>3/11</i> , 1958, that I last saw the deceased alive on <i>3/11</i> , 1958, and that death occurred at <i>6:30 P</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Ivory U. Sully, Jr.</i> M.D.		ADDRESS (Street, city or town, state) <i>Berlin, Md</i>	
PHYSICIAN'S NAME (Type) <i>Ivory U. Sully, Jr.</i>		DATE SIGNED <i>3/11/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>3/12/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>ST. PAUL'S</i>	22d. LOCATION (City, town, or county) (State) <i>Berlin Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Anna H. Burdette</i>		ADDRESS <i>Berlin Md</i>	
24a. REC'D BY REGISTRAR <i>MIR 13 '58</i>		24b. REGISTRAR'S SIGNATURE <i>W. Beach</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2000193XV3

CERTIFICATE OF DEATH

Form No. 10

1. NAME OF DECEASED <i>John D. Smith</i>		2. SEX <i>Male</i>		3. AGE <i>65</i>	
4. DATE OF DEATH <i>March 10, 1958</i>		5. PLACE OF DEATH <i>Home</i>		6. CAUSE OF DEATH <i>Heart Disease</i>	
7. OCCASION OF DEATH <i>Heart Attack</i>		8. PLACE OF BIRTH <i>Baltimore, Md.</i>		9. DATE OF BIRTH <i>March 10, 1893</i>	
10. NAME OF PHYSICIAN <i>Dr. J. H. Smith</i>		11. NAME OF FUNERAL HOME <i>John D. Smith & Co.</i>		12. NAME OF MINISTER <i>Rev. J. H. Smith</i>	
13. NAME OF NEXT OF KIN <i>John D. Smith</i>		14. NAME OF SURVIVOR <i>John D. Smith</i>		15. NAME OF DECEASED'S MOTHER <i>John D. Smith</i>	
16. NAME OF DECEASED'S FATHER <i>John D. Smith</i>		17. NAME OF DECEASED'S SISTER <i>John D. Smith</i>		18. NAME OF DECEASED'S BROTHER <i>John D. Smith</i>	
19. NAME OF DECEASED'S CHILD <i>John D. Smith</i>		20. NAME OF DECEASED'S GRANDCHILD <i>John D. Smith</i>		21. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>	
22. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		23. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		24. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>	
25. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		26. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		27. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>	
28. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		29. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		30. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>	
31. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		32. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		33. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>	
34. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		35. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		36. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>	
37. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		38. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		39. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>	
40. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		41. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		42. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>	
43. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		44. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		45. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>	
46. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		47. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		48. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>	
49. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		50. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		51. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>	
52. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		53. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		54. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>	
55. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		56. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		57. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>	
58. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		59. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		60. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>	
61. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		62. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		63. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>	
64. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		65. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		66. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>	
67. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		68. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		69. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>	
70. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		71. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		72. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>	
73. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		74. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		75. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>	
76. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		77. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		78. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>	
79. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		80. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		81. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>	
82. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		83. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		84. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>	
85. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		86. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		87. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>	
88. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		89. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		90. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>	
91. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		92. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		93. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>	
94. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		95. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		96. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>	
97. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		98. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		99. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>	
100. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		101. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>		102. NAME OF DECEASED'S GREAT-GRANDCHILD <i>John D. Smith</i>	

BUREAU V. 8

MAR 13 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3994

CERTIFICATE OF DEATH

03975

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Worcester</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <i>md</i> b. COUNTY <i>Worcester</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>	c. LENGTH OF STAY IN 1b <i>2 yrs</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>1</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Philip</i> Middle <i>U.</i> Last <i>Dennis</i>		4. DATE OF DEATH Month <i>March</i> Day <i>25</i> Year <i>1958</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>Colored</i>	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 18-1876</i>
9. AGE (In years last birthday) <i>81 1/2</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Tenant Farmer</i>	
11. BIRTHPLACE (State or foreign country) <i>Missilee md</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>John Dennis</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Beckett</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or not known) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Mrs Harriet Adams</i>		Address <i>Snow Hill md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive Cardiovascular Disease.</i> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>3 yrs</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Aspiration Pneumonia</i> 491X			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>June</i> , 1955, to <i>March 25</i> , 1958, that I last saw the deceased alive on <i>March 24</i> , 1958, and that death occurred at <i>2:00 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Robert C. La Mar</i>		ADDRESS (Street, city or town, state) <i>Bay St., Snow Hill, Md.</i>	
PHYSICIAN'S NAME (Type) <i>Robert C. La Mar, M. D.</i>		DATE SIGNED <i>3-26-58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>March 27/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>West Cemetery</i>	22d. LOCATION (City, town, county) (State) <i>Snow Hill md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wayne Dennis</i>		24a. REC'D BY REGISTRAR DATE <i>MAR 28 '58</i>	
ADDRESS <i>Snow Hill, md</i>		24b. REGISTRAR'S SIGNATURE <i>Alfred Smith</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 10-15

BUREAU V. B.

MAR 28 1958

RECEIVED

Item 4 #11-2226 3-21-58 et
3995 CERTIFICATE OF DEATH

Reg. Dist. No. 03976

1. PLACE OF DEATH a. COUNTY <u>NORFOLK</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>NORFOLK</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X BERLIN (R.F.D.)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ROSA ELLEN DENNIS</u>		4. DATE OF DEATH Month Day Year <u>March 14, 1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 18, 1878</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>Wicomico Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ISAAC WILLIAM CLAYVILLE</u>		14. MOTHER'S MAIDEN NAME <u>AMELIA SMACK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>MISS RUTH DENNIS</u>		Address <u>BERLIN MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Nephritis</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chr. Nephritis</u> DUE TO (c) <u>Chr. Myocarditis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>30 days.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Mar 11, 1958</u> to <u>Mar 14, 1958</u> , that I last saw the deceased alive on <u>Mar 14, 1958</u> , and that death occurred at <u>6:20 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Chas. R. Law</u>		DATE SIGNED <u>Mar 15, 1958</u>	
PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/16/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>DENNIS CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PONCAVILLE MD RFD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anne A. Burby</u>		ADDRESS <u>Berlin Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE MAR 19 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

03977

Reg. Dist. No.

3996

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>				c. LENGTH OF STAY IN 1b <u>4 MONTHS</u> x <u>BERLIN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>BROAD ST.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>KATHARINE M. GARLICK</u>				4. DATE OF DEATH Month Day Year <u>MAR. 9 1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV 1, 1881</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BERLIN MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES MASSEY</u>				14. MOTHER'S MAIDEN NAME <u>HESTER JOHNSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT Address <u>MR. J. WILLIAM GARLICK, DEAN PTY, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO <u>Arteriosclerotic cerebrovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>331x</u> 3 yrs							INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491x Broncho-pneumonia - rt lower lobe</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 1957</u> , to <u>9 Mar 1958</u> , that I last saw the deceased alive on <u>9 Mar 1958</u> , and that death occurred at <u>2:25 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. R. Thomas</u> M.D.				ADDRESS (Street, city or town, state) <u>Green City, MD</u>		DATE SIGNED <u>10 Mar 58</u>	
PHYSICIAN'S NAME (Type) <u>N. R. Thomas</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/11/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Burbage Funeral Home, Berlin, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 10 1958</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
MAR 13 1958
BUREAU V. 1

STAR 13 1958

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3997 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03978

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Md b. COUNTY WOR	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Showell		c. LENGTH OF STAY IN 1b 20 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS RURAL - Showell	
3. NAME OF DECEASED (Type or print) First Middle Last Hugh "O" GREEN		4. DATE OF DEATH Month Day Year MAR 16 1958	
5. SEX M	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH UNKNOWN
9. AGE (In years last birthday) 60 3 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Field Hand		10b. KIND OF BUSINESS OR INDUSTRY Nursery	
11. BIRTHPLACE (State or foreign country) UNKNOWN - USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 222 20 4169	
17. INFORMANT Raymond Baker		Address Bishop, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DILATION OF HEART, ACUTE DUE TO A.S. CVD Conditions, if any, which gave rise to immediate cause (b) ? (c) DUE TO cause last.		INTERVAL BETWEEN ONSET AND DEATH INSTANT	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Francis J. Townsend, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANCIS J. TOWNSEND, JR.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3 19 1958	
22c. NAME OF CEMETERY OR CREMATORY Mt Calvary Cemetery		22d. LOCATION (City, town, or county) (State) Fruitland, Md	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart		ADDRESS Funeral Home, Salisbury, Md	
24a. REC'D BY REGISTRAR MAR 21 1958		24b. REGISTRAR'S SIGNATURE W. H. French	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. RACE <i>White</i>	
5. DATE OF DEATH <i>March 21, 1958</i>		6. PLACE OF DEATH <i>Home</i>	
7. OCCASION OF DEATH <i>Heart Attack</i>		8. CAUSE OF DEATH <i>Myocardial Infarction</i>	
9. MANNER OF DEATH <i>Natural</i>		10. SIGNATURE OF EXAMINER <i>[Signature]</i>	
11. SIGNATURE OF WITNESS <i>[Signature]</i>		12. SIGNATURE OF CORONER <i>[Signature]</i>	

BUREAU V. 3

MAR 21 1958

RECEIVED

CERTIFICATE OF DEATH

3998

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Stockton</u>				c. LENGTH OF STAY IN 1b <u>50 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RFD #2</u>				e. STREET ADDRESS <u>RFD #2</u>			
3. NAME OF DECEASED (Type or print) First <u>RAYMOND</u> Middle <u>W.</u> Last <u>HOLLAND</u>				4. DATE OF DEATH Month <u>March</u> Day <u>7</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 16, 1886</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John W. Holland</u>				14. MOTHER'S MAIDEN NAME <u>Laura Redden</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-14-0766</u>		17. INFORMANT <u>Mrs Blanche M. Holland, Stockton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia and Inanition</u> <u>180X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Transitional Cell Carcinoma Right Kidney with metastases</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>6 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Sept 57</u> , to <u>Mar 7</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Mar 6</u> , 19 <u>58</u> , and that death occurred at <u>5 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert C. La Mar</u>				ADDRESS (Street, city or town, state) <u>104 Bay St</u>		DATE SIGNED <u>3-8-58</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT C. LA MAR, M.D.</u>				<u>Snow Hill</u>		<u>Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-9-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Episcopal Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Stockton, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S. Watson</u>				ADDRESS <u>Pocomoke, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 11 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. Search</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

3985

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City				c. LENGTH OF STAY IN 1b 1 year			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 218 Walnut Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle T. Last HOSMER				4. DATE OF DEATH Month March Day 3 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 18, 1872	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William H. Toman				14. MOTHER'S MAIDEN NAME Harriett Raymond			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs Edward W. Ham, Pocomoke City, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 593x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Nephritis DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 3 days Undetermined	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension, Degenerative Heart Disease, Atherosclerosis.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. , 19 54 , to March 3 , 19 58 , that I last saw the deceased alive on March 3 , 19 58 , and that death occurred at 315P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 3-4-58							
ACTUAL SIGNATURE <i>Charles W. Trader</i>		PHYSICIAN'S NAME (Type) Charles W. Trader, M.D., 302 Market St., Pocomoke City, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-7-58		22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cherokee, Iowa	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry Watson</i>				ADDRESS Pocomoke City, Md.		24a. REC'D BY REGISTRAR DATE MAR 10 '58	
				24b. REGISTRAR'S SIGNATURE <i>W. Smith</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 10 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3999

CERTIFICATE OF DEATH

Reg. Dist. No.

03981

1. PLACE OF DEATH a. COUNTY Worcester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stockton		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stockton		d. STREET ADDRESS P.O. Box	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Bessie		Middle Jones		Last		4. DATE OF DEATH Month March	
Day 15		Year 1958					
5. SEX F.		6. COLOR OR RACE C.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 21, 1897	
9. AGE (In years last birthday) 61		IF UNDER 1 YEAR Months 6		IF UNDER 24 HRS. Days 4		Hours 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John H. Williams		14. MOTHER'S MAIDEN NAME Adline Hill					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Leroy Jones		Address Stockton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) Essential Hypertension				INTERVAL BETWEEN ONSET AND DEATH 4 days 6 wks 9 wks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 490X Obesity @ developing lobar pneumonia				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/15/58 , 19 58 , to 3/18/58 , 19 58 , that I last saw the deceased alive on 3/15/58 , 19 58 , and that death occurred at 10 A.M. , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 801 - 4th St, Pocomoke		DATE SIGNED 3/18/58	
ACTUAL SIGNATURE Beal & Duveney		M.D.					
PHYSICIAN'S NAME (Type) Edgar Wharton							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/18/58		22c. NAME OF CEMETERY OR CREMATORY St. Paul Cem.		22d. LOCATION (City, town, or county) (State) Stockton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar Wharton		ADDRESS new church, 1/4		24a. REC'D BY REGISTRAR MAR 24 '58		24b. REGISTRAR'S SIGNATURE Beal & Duveney	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in b, funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

THE DEATH OF

BUREAU V. E.

MAR 24 1933

RECEIVED

4700

Item 8 Film 227 3-28-58 et

CERTIFICATE OF DEATH

03982

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DELAWARE</u> b. COUNTY <u>Sussex</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BISHOPVILLE RD.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FRANKFORD, Del.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>46X-3</u>			
3. NAME OF DECEASED (Type or print) First <u>LILLIE</u> Middle <u>M.</u> Last <u>LYNCH</u>				4. DATE OF DEATH Month <u>3</u> Day <u>12</u> Year <u>1958</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-7-1891</u> 1880	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>WOOLSEY TOOMEY</u>			
14. MOTHER'S MAIDEN NAME <u>ELIZA HITCHENS</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address <u>VIRGEN McBEE BISHOPVILLE MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary sclerosis,</u> DUE TO (c) <u>Arteriosclerotic heart disease</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July</u> , 19 <u>57</u> , to <u>March 12</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>March 12</u> , 19 <u>58</u> , and that death occurred at <u>9:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Miss Maresch</u> M.D.				ADDRESS (Street, city or town, state) <u>Dagsboro, Del.</u> DATE SIGNED <u>3/15/58</u>			
PHYSICIAN'S NAME (Type) <u>R. E. MARESCH</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/15/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ROXANA CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ROXANA DEL</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Watson & Gray</u> ADDRESS <u>Frankford Del.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 18 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. E. ...</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

MAR 18 1958

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Newark</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Newark</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Myra</u> (MYRA) Middle <u>V.</u> Last <u>Palmer</u>		4. DATE OF DEATH Month <u>March</u> Day <u>11</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 21-1880</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Snow Hill, Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Charles Smack</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Hamlin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Howard Palmer, Newark Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Pneumonia</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension Cardio-vascular</u> DUE TO (c) <u>arteriosclerotic renal disease</u> Interval between onset and death <u>1 wk</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>493X</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 4, 1958</u> , to <u>March 11, 1958</u> , that I last saw the deceased alive on <u>March 9, 1958</u> , and that death occurred at <u>9:00 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Samuel Cohen</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial March 15/58</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Bowen Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Newark, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne Dennis</u>		ADDRESS <u>Snow Hill, Md</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Deborah</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 14 1953

RECEIVED

4702

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY WORCESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY WORCESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN	c. LENGTH OF STAY IN 1b 50 YRS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X BERLIN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS N. MAIN ST	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First NORMAN Middle MELSON Last PETERS		4. DATE OF DEATH Month MAR. Day 9 Year 1958	
5. SEX M.	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 9, 1886
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT		10b. KIND OF BUSINESS OR INDUSTRY REARITY	
11. BIRTHPLACE (State or foreign country) SNOW HILL, MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME REECE C. PETERS		14. MOTHER'S MAIDEN NAME LAVINIA WEST	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give year or dates of service) NO		16. SOCIAL SECURITY NO. 216-32-5841	
17. INFORMANT MRS. NORMAN M. PETERS		Address BERLIN MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 446X Congestive Cardiac failure DUE TO (b) Uremia & nephrosclerosis DUE TO (c) Cerebral vascular accident. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 3 days 1-2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) atherosclerosis.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Mr. March 9, 1958 to March 11, 1958 , that I lost saw the deceased alive on March 9, 1958 , and that death occurred at 5:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert A. Grubb MD		ADDRESS (Street, city or town, state) 5 BAY ST. BERLIN MD DATE SIGNED 3/11/58	
PHYSICIAN'S NAME (Type) ROBERT A. GRUBB.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3/11/58	22c. NAME OF CEMETERY OR CREMATORY EVANGELINE Cem	22d. LOCATION (City, town, or county) (State) BERLIN MD
23. FUNERAL DIRECTOR'S SIGNATURE Anna A. Burbage Berlin Md		24a. REC'D BY REGISTRAR DATE MAR 13 '58	
ADDRESS Anna A. Burbage Berlin Md		24b. REGISTRAR'S SIGNATURE Overman	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 13 1958

RECEIVED

4003

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Worcester</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Worcester</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Girdletree, Rural #1</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Girdletree Rural #1</i>			
c. LENGTH OF STAY IN 1b <i>64 yrs</i>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <i>Basil</i> Middle <i>H.</i> Last <i>Riley</i>				4. DATE OF DEATH Month <i>March</i> Day <i>25</i> Year <i>1958</i>			
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>July 25-1893</i>	
9. AGE (In years last birthday) <i>64 8/10</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		11. BIRTHPLACE (State or foreign country) <i>Girdletree md</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>James E. Riley</i>				14. MOTHER'S MAIDEN NAME <i>Mary Stanford</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>				16. SOCIAL SECURITY NO. <i>220-34-9919</i>		17. INFORMANT <i>Mrs. Lattie J. Riley, Girdletree, md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <i>1 Day</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <i>1945</i> , 19____, to <i>March 25, 1958</i> , that I last saw the deceased alive on <i>March 24, 1958</i> , and that death occurred at <i>5:00 P.</i> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Paul Cohen</i> M.D.				ADDRESS (Street, city or town, state) <i>Snow Hill Md</i> DATE SIGNED			
PHYSICIAN'S NAME (Type) _____							
22. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>March 29/58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Spring Hill Cemetery</i>		22d. LOCATION (City, town, or county) <i>Girdletree, md</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wayne Dennis</i>				ADDRESS <i>Snow Hill, md</i>		24a. REC'D BY REGISTRAR <i>Q. B. Smith</i>	
				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be delivered by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
MAR 28 1958
BUREAU V. A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4704

CERTIFICATE OF DEATH

03986

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Worcester</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Berlin Rural #1</i> c. LENGTH OF STAY IN b. <i>4 yrs</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md</i> b. COUNTY <i>Worcester</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Berlin Rural #1</i> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Dallie</i> Middle <i>F</i> Last <i>Shackley</i> 4. DATE OF DEATH Month <i>March</i> Day <i>9</i> Year <i>1958</i>		5. SEX <i>Female</i> 6. COLOR OR RACE <i>White</i> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <i>April 6 - 1879</i> 9. AGE (In years last birthday) <i>78 11/13 yrs.</i> IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> 10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i> 11. BIRTHPLACE (State or foreign country) <i>Staebler, md</i> 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>Isaac Hancock</i> 14. MOTHER'S MAIDEN NAME <i>Margaret Jones</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT <i>Mrs. Mary S. Richardson</i> Address <i>Berlin, md</i> <i>Rural #1</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Thrombosis</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } CORONARY ARTERY DISEASE & CHRONIC MYOCARDITIS DUE TO (c) <i>5 yrs.</i> INTERVAL BETWEEN ONSET AND DEATH <i>15 min</i>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Lymphoma, stomach operated 1952</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Nov</i> , 19 <i>41</i> , to <i>March 9</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>March 9</i> , 19 <i>58</i> , and that death occurred at <i>8:15</i> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Berlin, Md</i> DATE SIGNED <i>W. Beach</i>			
ACTUAL SIGNATURE <i>Hannah Kable</i> M.D. <i>Berlin, Md</i>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<i>Burial</i>		<i>March 12/58</i>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<i>St. Bonaventure</i>		<i>Snow Hill, md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
<i>Wayne Sumner</i>		DATE <i>MAR 12 '58</i>	
ADDRESS <i>Snow Hill, md</i>		24b. REGISTRAR'S SIGNATURE <i>W. Beach</i>	

BUREAU V. B.

MAR 12 1958

RECEIVED

Reg. Dist. No. 03987

3936

1. PLACE OF DEATH a. COUNTY Worcester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke		c. LENGTH OF STAY IN 1b 42 Pocomoke	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1 Pocomoke, Md.	
3. NAME OF DECEASED (Type or print) Marie Smith		4. DATE OF DEATH Month March Day 9th. Year 1958	
5. SEX Female	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 11, 1896
9. AGE (In years last birthday) yrs. 61		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Housework	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Millie Hayward	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218 10 8058	
17. INFORMANT Norman Smith - Pocomoke, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema DUE TO (b) Congestive Heart Failure DUE TO (c) Essential Hypertensive Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Essential Hypertension			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 day 3 mths 4 mths	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/14/1948 , to 3/8/1958 , that I last saw the deceased alive on 3/8/58 , 19 58 , and that death occurred at 4:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 801 - 4th St, Pocomoke DATE SIGNED 3/13/58 ACTUAL SIGNATURE Wesley A. Dwyer M.D. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 16, 1958	
22c. NAME OF CEMETERY OR CREMATORY Unionville Cem.		22d. LOCATION (City, town, or county) (State) Pocomoke, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar Wharton - New Church, Va.		24a. REC'D BY REGISTRAR DATE MAR 17 '58	
24b. REGISTRAR'S SIGNATURE Wesley A. Dwyer			

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 10

MAR 17 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4005

CERTIFICATE OF DEATH

03988

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shridette</u>		c. LENGTH OF STAY IN TB <u>70 yrs</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shridette</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Peter</u> Middle <u>C.</u> Last <u>Sturgis</u>		4. DATE OF DEATH Month <u>March</u> Day <u>23</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>1879</u>
9. AGE (In years last birthday) <u>79</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waltman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Impudent Bay</u>	
11. BIRTHPLACE (State or foreign country) <u>Shridette, md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Swing Sturgis</u>		14. MOTHER'S MAIDEN NAME <u>Matilda Swift</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs Joseph Andrews, Shridette, md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic cardiovascular disease</u> (c) <u>disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1945</u> , 19 to <u>3/23/58</u> , 19, that I last saw the deceased alive on <u>3/22/58</u> , 19, and that death occurred at <u>9:00 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul Cohen</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Snow Hill Md</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 24/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baptist Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Shridette md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne E. Rimmis</u>		ADDRESS <u>Snow Hill, md</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 26 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. E. Rimmis</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 100-1

Blank form for Certificate of Death with various fields for registration, medical history, and cause of death.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

BUREAU V. S.

MAR 26 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **03989**

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean City		c. LENGTH OF STAY in 1b 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rideau Hotel		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edward CLARK TRADER		4. DATE OF DEATH Month March Day 29 Year 1958	
5. SEX Male	6. COLOR OF RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 21 1897
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE - Hotel		10b. KIND OF BUSINESS OR INDUSTRY Hotel	
11. BIRTHPLACE (State or foreign country) SANFORD VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William PARKER TRADER		14. MOTHER'S MAIDEN NAME Jenny ONLEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 214-12-6096	
17. INFORMANT MRS FRANCES JANE TRADER, WIFE, Berlin, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY Occlusion Acute DUE TO (b) Arterio Sclerotic CVD DUE TO (c) 6 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BRONCHITIS, CHRONIC		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE Francis James Townsend, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Francis James Townsend, Jr.		DATE SIGNED MAR 29, 58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-1-58	
22c. NAME OF CEMETERY OR CREMATORY SALEM METHODIST		22d. LOCATION (City, town, or county) (State) POCOMOKE CITY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Thurston Watson		24a. REC'D BY REGISTRAR DATE APR 3 '58	
ADDRESS POCOMOKE, MD.		24b. REGISTRAR'S SIGNATURE W. Leach	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-CALCULORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
APR 3 1958
BUREAU V. S.

4007

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Worcester</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>md</i> b. COUNTY <i>Worcester</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Shillinee</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Shillinee</i>			
c. LENGTH OF STAY IN 1b <i>60 yrs</i>				d. STREET ADDRESS <i>1</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Horace</i> Middle <i>L.</i> Last <i>Well</i>				4. DATE OF DEATH Month <i>March</i> Day <i>28</i> Year <i>1958</i>			
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>March 16-1894</i>	
9. AGE (In years last birthday) <i>64</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Wallman</i>		11. BIRTHPLACE (State or foreign country) <i>Accomack City, md</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>John Well</i>				14. MOTHER'S MAIDEN NAME <i>Annie Turnace</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>220-32-0418</i>			
17. INFORMANT <i>Mrs Emma Well, Shillinee, md</i>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Coronary Thrombosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>2 days</i> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I attended the deceased from <i>1955</i> , 19____, to <i>3/28/58</i> , 19____, that I last saw the deceased alive on <i>3/27/58</i> , 19____, and that death occurred at <i>11:00 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>Paul Cohen</i> M.D. <i>Snow Hill Md 3/29/58</i>							
ACTUAL SIGNATURE				PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF			
22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE				24a. REC'D BY REGISTRAR			
24b. REGISTRAR'S SIGNATURE				DATE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
CERTIFICATE OF DEATH

1938

BUREAU V. S.

APR 1 1938

RECEIVED

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1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4908

CERTIFICATE OF DEATH

03991

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eden				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Eden			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 1				d. STREET ADDRESS R.D.# 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last CARL WILLIAM WILSON				4. DATE OF DEATH Month Day Year MARCH 22nd 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 22, 1900	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months 2 Days 0		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Worcester Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Josiah F. Wilson				14. MOTHER'S MAIDEN NAME Lina Shockley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Nettie M. Wilson (Wife) R.D.# 1 Eden Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute Anterior Myocardial Infarction 3-4 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Hypertensive Cardiovascular Dis. 2 yrs (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/22, 1958, to 3/22, 1958, that I last saw the deceased alive on 3/22, 1958, and that death occurred at 9:10 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Rufus Gardner Jr. M.D. Punchbloss Rd. PHYSICIAN'S NAME (Type) Dr. Rufus Gardner Jr. Salisbury, Maryland Mar. 25, 1958							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 25, 1958		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS HOLLOWAY & COMPANY - SALISBURY MARYLAND				24a. REC'D BY REGISTRAR DATE MAR 28 '58		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 17

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JAN 22, 1958	
AGE		SEX	
65		M	
RACE		OCCUPATION	
W		C	
BIRTH DATE		BIRTH PLACE	
JAN 1, 1893		BALTIMORE, MD	
MARRIAGE DATE		MARRIAGE PLACE	
JAN 1, 1915		BALTIMORE, MD	
EDUCATION		RELIGION	
H		C	
PREVIOUS ILLNESS		CAUSE OF DEATH	
H		H	
PLACE OF DEATH		MANNER OF DEATH	
H		H	
CERTIFICATE OF DEATH		SIGNATURE OF DECEASED	
H		H	

BUREAU V. E

MAR 28 1958

RECEIVED

HOLLAND & COMPANY - BALTIMORE, MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3987

CERTIFICATE OF DEATH

Reg. Dist. No. 03992

1. PLACE OF DEATH o. COUNTY <i>Worcester</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Worcester</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pocomoke</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pocomoke, Md.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Home</i>		d. STREET ADDRESS <i>Rt 3 Box 98</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Florence Lee Wise</i>		4. DATE OF DEATH Month Day Year <i>MARCH 17 1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 15, 1884</i>
9. AGE (In years last birthday) <i>73</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Collins</i>		14. MOTHER'S MAIDEN NAME <i>Katherine Balla</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>NONE</i>	
17. INFORMANT Address <i>Edward Wise Pocomoke, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>March 7, 1958</i> , to <i>March 17, 1958</i> , that I last saw the deceased alive on <i>March 16, 1958</i> , and that death occurred at <i>4 A.</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>E. Ditcher</i> M.D.		DATE SIGNED <i>March 24 1958</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3/23/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Wardtown</i>	22d. LOCATION (City, town, or county) (State) <i>Pocomoke, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar Wharton</i> ADDRESS <i>New Church, Va.</i>		24a. REC'D BY REGISTRAR DATE <i>MAR 24 '58</i>	24b. REGISTRAR'S SIGNATURE <i>W. J. Smith</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

MAR 24 1966

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 3, 3988 REG G-228 5/12/58.cac

Reg. Dist. No. 03993

1. PLACE OF DEATH a. COUNTY <i>Worcester</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Worcester</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pocomoke City</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pocomoke City</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>John Sylvester Wise</i> First (Also known as <i>Joshua Wise</i>)		4. DATE OF DEATH Month <i>13</i> Day <i>3</i> Year <i>1958</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 15-1895</i>
9. AGE (In years last birthday) <i>63</i> yrs.		IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	
11. BIRTHPLACE (State or foreign country) <i>Worcester Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Wm Edward Wise</i>		14. MOTHER'S MAIDEN NAME <i>Mary Grace Collins</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <i>yes World War I</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Eric Elizabeth Evans (a Sister)</i>		Address <i></i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Alcoholism (Probable)</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i></i> DUE TO (c) <i></i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>His living quarters and environment</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>	
20c. TIME OF INJURY Hour <i>19</i> o. m. <i></i> p. m. <i></i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) (County) (State) <i></i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input checked="" type="checkbox"/> .			
ACTUAL SIGNATURE <i>N. E. Sartorius Jr</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>N. E. Sartorius</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3-9-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Halls Hill</i>	22d. LOCATION (City, town, or county) (State) <i>Pocomoke Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar Wharton</i>		ADDRESS <i>New Church, Va.</i>	
24a. REC'D BY REGISTRAR <i></i>		24b. REGISTRAR'S SIGNATURE <i>W. Beach</i>	
DATE <i>MAR 10 '58</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

BUREAU V. 31

MAR 10 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03994

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland c. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Highway 113		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mable Middle Eline Last Wise		4. DATE OF DEATH Month March Day 15 Year 1958	
5. SEX Female	6. COLOR OR RACE O.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 3, 1931
9. AGE (In years last birthday) 26 yrs.		10. IF UNDER 1 YEAR Months 15 Days 15 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Bus Driver		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elton Wise		14. MOTHER'S MAIDEN NAME Blanche Core	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Elton Wise , Pocomoke City, Md.	
17. INFORMANT Elton Wise , Pocomoke City, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Traumatic Asphyxiation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Fracture of Neck DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of Neck			
INTERVAL BETWEEN ONSET AND DEATH (0) (0)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Person was thrown from car, which then rolled on her	
20c. TIME OF INJURY Month, Day, Year 2:50 p.m. March 15 1958	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, ship, etc.) Along Md. 113	20f. (City or town) (County) (State) 3 Miles N. of Pocomoke City Md
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Robert C. La Mar		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Robert C. La Mar, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 3-17-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/19/58	22c. NAME OF CEMETERY OR CREMATORY Halls Hill	22d. LOCATION (City, town, or county) (State) Pocomoke Md.
23. FUNERAL DIRECTOR'S SIGNATURE Edgar Wharton - New Church, Md.		24a. REC'D BY REGISTRAR MAR 24 '58	
ADDRESS		24b. REGISTRAR'S SIGNATURE Quitch	

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MASSACHUSETTS STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 21

MAR 24 1908

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